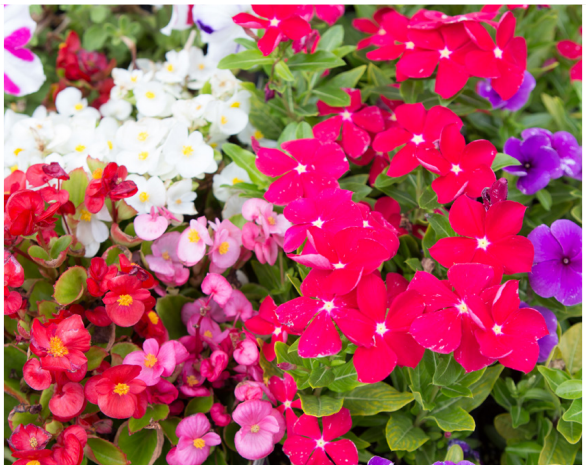
BALTIMORE COUNTY GOVERNMENT

RETIREE BENEFITS GUIDE 2021

BaltimoreCountyMD.gov/Benefits



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Baltimore County Government Important Contacts

CONTACT:	REGARDING:
Insurance Division, Office of Budget and Finance 400 Washington Ave., Rm 111 Towson, MD 21204 **Phone: 410-887-2568 or 800-274-4302** **Fax: 410-887-3820** **Email: bcbenefits@baltimorecountymd.gov** **Internet: www.baltimorecountymd.gov/benefits**	■ Who is eligible for County health plan coverage ■ General benefit questions ■ Life status changes–i.e. marriage, divorce, birth, adoption, death of dependents, loss of dependent status ■ All non medicare benefit enrollments ■ Dental and vision enrollments for Medicare retirees. ■ Changes to life insurance beneficiaries ■ Assistance with benefits elections when retiring ■ Continuing benefits under COBRA if you or your dependent(s) lose County benefits
MEDICARE RETIREES ONLY **Labor First, LLC** 3000 Midlantic Drive, Suite 101 Mount Laurel, NJ 08054 **Phone: 410-431-2226 or Toll Free 855-499-2656** **Email: Members@laborfirst.com** **Internet: www.laborfirst.com**	■ Medical and Prescription billing questions ■ Assist with enrollment ■ Eligibility verification from providers ■ Medical and Prescription prior authorizations ■ Drug and copay look up ■ Provider and pharmacy network questions ■ Medicare/SSA assistance and many more
Baltimore County Retirement Office 400 Washington Ave., Rm 169 Towson, MD 21204 **Phone: 410-887-8246 or 877-222-3741** **Email: ers@baltimorecountymd.gov**	■ Questions about your pension benefits ■ Questions about who you designated as your retirement beneficiary ■ Requests for retirement conferences ■ Changes to your address or other retirement information on file ■ Life status changes - i.e. marriage, divorce, or death of dependent spouse or other retirement beneficiary
NON MEDICARE RETIREES ONLY **Baltimore County Employee Assistance Program** **(Administered by Cigna Behavioral Health)** **Phone: 888-431-4334** **www.myCigna.com (password: baltimore)**	■ Assistance with short-term, confidential, no-cost counseling for mental health, substance abuse and/or other work or family issues
Social Security Administration (SSA) **Phone: 800-772-1213** **Internet: www.ssa.gov**	■ Change of address ■ General Medicare Part A or B eligibility or premiums
Medicare Help Line **Phone: 1-800-MEDICARE (633-4227)** **Internet: www.medicare.gov**	■ Request new ID card ■ Ordering Medicare publications ■ General Medicare information

The purpose of this Benefit Guide is to give you basic information about your benefit options and how to enroll for coverage or make changes to existing coverage. This Guide is only a summary of your choices and does not fully describe each benefit option. Please refer to the plan documents for important additional information about the plans.

Enrollment and Eligibility Guidelines

Open Enrollment Information

Benefits changes for all retirees must be completed between October 26, 2020 and November 27, 2020. Changes will be effective January 1, 2021.

Eligibility

- In order to qualify for subsidized health insurance benefits as a retiree, the member must have 10 or more creditable years of County service prior to retirement and must be receiving a pension check sufficient to cover the retiree's share of the health plan premium deductions. (Retirees that retired prior to 7/1/2006 must have 5 or more creditable years of County service prior to retirement, in order to qualify for subsidized health insurance benefits as a retiree.)
- Employees with 30 or more years of service not contributing to the Baltimore County Employees' Retirement System, may participate in County group insurance plans or partnerships with no County subsidy when they retire. This means that County employees in this category are eligible to remit 100% of the premium for plans that they or their dependents are eligible for.

Dependent Eligibility

- **Spouse** (opposite and same sex marriage must be legally recognized)
- **Dependent child** up to the end of the month in which they reach age 26, regardless of whether the dependent is married, a student or non-student, residing at home or residing outside the home **and who is:**
  - The retiree or spouse's child by birth or legal adoption recognized under Maryland law
  - A child under testamentary or court appointed guardianship recognized under Maryland law who resides with the employee or spouse
  - A child who is the subject of a Qualified Medical Child Support Order (QMCSO) that creates the right of the child to receive health insurance benefits under an employee or retiree's coverage.

Eligible dependents are required to have legal standing and/or legally sufficient documentation for residency in the United States while included on County health plans.

Including your dependent(s) on County benefit plans when they do not meet County eligibility requirements is fraudulent and subject to prosecution.

Medicare Retirees Eligibility (Due to Age or Disability)

Baltimore County requires that as soon as a retiree or spouse of a retiree is eligible for Medicare due to age or disability, that they accept Medicare as their primary health insurance. It is very important to obtain both Part A (Hospital) and Part B (Medical) of Medicare. Typically, Medicare becomes effective the first day of the month in which you reach age 65 or otherwise become eligible due to disability. For additional information regarding Medicare, please contact Social Security.

Once enrolled in Medicare, you or your spouse, will be eligible to enroll in a Medicare Advantage, Medicare Supplemental and/ or Part D Prescription plan offered through Labor First. Please notify Labor First at (410) 431-2226 as soon as you are enrolled in Medicare to discuss your Medical and Prescription plan options. Dental and Vision enrollments will still be administered by Baltimore County Government.

What If My Spouse or I are Not Eligible for Medicare?

You may not be eligible for Medicare if you did not work the required number of quarters required by the Social Security Administration. If you do not qualify on your own, you may qualify for spousal coverage. You will need to contact your local Social Security office to determine whether you can enroll in Medicare. Those few retirees not eligible for Medicare either on their own or through a spouse should contact the Insurance Division upon reaching their 65th birthday to discuss their options.

What if I Become Eligible for Medicare but My Spouse is Not Yet Eligible?

You will be enrolled in a Medicare Supplemental plan and your spouse can continue in a non-Medicare plan until they are eligible for Medicare (same applies if spouse is eligible before retiree). You will pay for Individual coverage in each of the plans.

Widow and Widower Eligibility

Depending on the option chosen at the time of retirement and the classification of the retiree, health plan benefits may be available to a widow/widower with a subsidy from Baltimore County. For this reason, it is very important to give a great deal of consideration to your retirement option at the time you elect to retire.

Baltimore County will subsidize the cost of coverage for a widow/ widower whose spouse was killed in the line of duty at the same level as active employees. Other widow/widower plan costs will be based on the date of retirement and the retiree's creditable years of service. The widow/widower must be receiving a pension check sufficient to cover their share of the health plan premium deductions. If you choose a pension option that will not provide payments sufficient to cover benefits for your spouse upon your death, your spouse will not be eligible for County subsidized benefits.

If a widow/widower remarries, the new spouse is not eligible for coverage under a County sponsored health plan. Widow/widowers not receiving a pension amount sufficient to cover benefits would be eligible for 36 months of COBRA coverage if necessary. COBRA coverage is not subsidized by the County and requires that the participant pay 102% of the actual plan premium.

Changes During the Year

It is your responsibility to notify the Insurance Office within 31 days each time you have a change in your Family Status. You must provide proof of the change requested (i.e. – a copy of the divorce decree, separation agreement to remove a spouse from coverage, or copy of birth certificate to add newborn.) Changes to benefits will be effective the 1st of the month after the Insurance Division receives your change request and appropriate documentation.

Contact the County Insurance Division at **410-887-2568** or **1-800-274-4302** if any of the information on your benefit records changes. Examples include:

- Birth or adoption of a new child – children must be added to your coverage within 31 days of birth or adoption even if you already have family coverage
- Marriage, Divorce or Legal Separation
- Loss of dependent child status – child is turning 26.
- Medicare eligibility due to age or disability
- Loss or gain of other coverage
- You move to a new residence outside Maryland that is not included in your current health plan's coverage area.

Changes During Open Enrollment

Examples of changes you may need to make during Open Enrollment include:

- Adding or removing a dependent if you did not do so within first 31 days of the qualifying event
- Changing the medical, dental or other plans you currently have

Cigna Open Access Plus (OAP)

With the Open Access Plus plan (OAP), you get choice. So, each time you need care, you choose the doctor or facility that works best for you.

Options for Care

- **Primary Care Physician (PCP)** – You can decide to choose a PCP as your personal doctor to help coordinate care and act as a personal health advocate. It's recommended, but not required.
- **In-network** – Choose to see doctors or other health professionals who are in the Cigna network to keep your costs lower and eliminate paperwork.
- **No-referral specialist care** – If you need to see a specialist, you don't need a referral.

  You may need precertification for hospital stays and some types of outpatient care. Use in-network health care professionals, and there's no paperwork for you to fill out.
- **Out-of-network** – You have the freedom to see doctors or use facilities that are not part of the Cigna network, but your costs will be higher and you may need to file a claim.
- **Emergency and urgent care** – When you need care, you have coverage.
- **24/7 service** – Whenever you need us, customer service representatives are available to take your call: 1-800-896-0948.

Predictable out-of-pocket costs – Depending on your plan, you may have to pay an annual amount (deductible) before the plan begins to pay for covered health care costs. Once you meet your deductible, you pay a copay or coinsurance (a portion of the charges) for covered services. Then, the plan pays the rest. If you receive out-of-network care, out-of-network doctors and facilities may bill you for charges that are more than what your plan pays for covered expenses.

Once you reach an annual limit on your payments (out-of-pocket maximum), the health plan pays your covered health care costs at 100%.

Cigna Virtual Care

With virtual care, you get the care and attention you'd expect from an in-office visit, wherever and whenever is most convenient for you. Virtual care options let you talk privately with a licensed counselor psychiatrist, or board-certified doctor via video or phone. Wellness screenings are also available through MDLive. Simply make your appointment online and go for a quick visit to a lab for your blood work and biometrics. The rest is completed online and via video or phone, wherever it's most convenient for you. You'll receive a summary of your screening results for your records.

Virtual care is designed to handle minor, nonemergency medical issues. You should NOT use tele-health if you are experiencing a medical emergency. If you have a medical emergency, you should dial 911 immediately or visit the nearest hospital.

Behavioral/Mental Health Virtual Care

With behavioral/mental health virtual care, you get the care and attention you'd expect from an in-office visit, wherever and whenever is most convenient for you. Here's how it works.

› Talk privately with a licensed counselor or psychiatrist via video or phone.

To schedule an appointment online, go to **myCigna.com**. Or, call MDLIVE directly at **888.726.3171.**

Get treated for conditions, such as:

- Addictions
- Depression
- Life changes
- Parenting issues
- Relationship/ marriage issues
- Stress

Visit **myCigna.com**, go to "Find Care & Costs" and enter "Virtual counselor" under Doctor by Type.

Cigna Open Access Plus In-Network (OAPIN)

With the Open Access Plus In-network plan, you get access to a large network of health care professionals and facilities. So, each time you need care, you choose the in-network doctor or facility that works best for you.

Enroll in the Open Access Plus In-network plan and get these options for care:

- **Primary Care Physician (PCP)** – You can decide to choose a PCP as your personal doctor to help coordinate care and act as a personal health advocate. It's recommended, but not required.
- **In-network** – For your health care to be covered by the plan, you must choose a health care professional who is in the Cigna Open Access Plus network.
- **No-referral specialist care** – If you need to see a specialist, you don't need a referral to see an in-network doctor.

  You may need precertification for hospital stays and some types of outpatient care. Use in-network health care professionals, and there's no paperwork for you to fill out.
- **Out-of-network** – If you choose to see a doctor who is not in the network, you will not have coverage except in emergencies.
- **Emergency and urgent care** – When you need care, you have coverage.
- **24/7 service** – Whenever you need us, customer service representatives will take your call – 1-800-896-0948.

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Get treated for conditions, such as:

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- Depression
- Life changes
- Parenting issues
- Relationship/ marriage issues
- Stress

To find a Cigna Behavioral Health network provider:

Visit **myCigna.com**, go to "Find Care & Costs" and enter "Virtual counselor" under Doctor by Type.

Cigna High Deductible Health Plan (HDHP)

In partnership with Cigna and Benefit Strategies, Baltimore County will be offering a high deductible health plan (HDHP) that can be combined with a health savings account (HSA) effective January 1, 2021. The Cigna High Deductible Health Plan (HDHP) can help you take control of your health and your costs. A HDHP offers you a typical medical plan at a higher deductible (the amount you pay before your plan starts to pay).

Options for Care

- **Primary Care Physician (PCP) –** You can decide to choose a PCP as your personal doctor to help coordinate care and act as a personal health advocate. It's recommended, but not required.
- **In-network –** Choose to see doctors or other health professionals who are in the Cigna network to keep your costs lower and eliminate paperwork.
- **No-referral specialist care –** If you need to see a specialist, you don't need a referral. You may need precertification for hospital stays and some types of outpatient care. Use in-network health care professionals, and there's no paperwork for you to fill out.
- **Out-of-network –** You have the freedom to see doctors or use facilities that are not part of the Cigna network, but your costs will be higher and you may need to file a claim.
- **Emergency and urgent care –** When you need care, you have coverage.
- **24/7 service –** Whenever you need us, customer service representatives are available to take your call: 1-800-896-0948.

The pros and cons of an HDHP

Pros

Lower monthly premium/plan contribution – If you anticipate only needing preventive care, then the lower premiums/plan contributions that often come with a HDHP may help you save money in the long run.

Tax-advantaged spending account – Non Medicare Retirees under age 65 may contribute to an HSA to help pay for eligible medical expenses and potentially take advantage of catch-up contributions based on age. For additional information contact Benefit Strategies at 888-401-3539.

Cons

Higher deductible – You are required to pay for your medical care out-of-pocket up to your deductible amount before your health plan begins to help pay for covered costs.

Costly out-of-pocket medical expenses – If you need non-preventive medical

Helpful HDHP Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.

Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent.

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Cigna OAP/OAPIN/HDHP

Frequently Asked Questions

How do I find out if my doctor is in the Cigna network before I enroll?

Our dedicated **Enrollment Information Line** is available 24/7 to help you learn about the benefits and advantages of Cigna. Call today and a knowledgeable Enrollment Specialist will provide you with assistance in identifying participating providers. Call **1-800-896-0948**.

Do I have to choose a Primary Care Physician (PCP)?

No. However, a PCP gives you and your covered family members a valuable resource and can be a personal health advocate.

Do I need a referral to see a specialist?

No. Though you may want your personal doctor's advice and assistance in arranging care with a specialist, you do not need a referral to see a participating specialist.

How does my plan cover my care?

When you visit a doctor who participates in the Cigna network, you receive in-network coverage. Participating health care providers have agreed to charge lower fees, and your plan covers a share of the charges. If enrolled in the OAPIN plan and you choose to visit a doctor outside of the network, your care will not be covered by your plan.

What if I need to be admitted to the hospital?

In an emergency, your care is covered. Requests for non-emergency hospital stays other than maternity stays must be approved in advance or "pre-certified." This enables Cigna to determine if the services are covered.

Precertification is not required for maternity stays of 48 hours for vaginal deliveries or 96 hours for caesarean sections. Depending on your plan, you may be eligible for additional coverage. Any hospital stay beyond the initial 48 or 96 hours must be approved.

Who is responsible for obtaining precertification?

Your doctor will help you decide which procedures require inpatient care and which can be handled on an outpatient basis. If your doctor participates in the Cigna network, he or she will arrange for precertification. If you use an out-of-network doctor your care will not be covered. Your plan materials will identify which procedures require precertification.

What is Case Management?

Case management is a program that assists customers with the hardships of an illness. A nurse Case Manager will help to coordinate the most appropriate care and works with you, your family and your physicians for the best results.

What if I go to an out-of-network physician who sends me to a network hospital? Will I pay in-network or out-of-network charges for my hospitalization?

Cigna will cover authorized medical services provided by an Open Access Plus participating hospital at your in-network benefits level—whether you were sent there by an in- or out-of-network doctor.

Why would Cigna call me?

Your employer offers you Cigna programs to help you get healthy and live well. When we call, we want to start a conversation so we can learn what's important to you – whether that's a chronic condition, making healthy choices, or filling a prescription. You may also be eligible for incentives for your participation. Every phone call is private and confidential.

Can Express Scripts Pharmacy help transfer my current prescription from my local retail pharmacy?

Yes. Simply call 800.835.3784 and have your doctor's contact information and prescription medication name(s) and dosage(s) ready. Express Scripts Pharmacy will do the rest.

Cigna OAP/OAPIN/HDHP

Resources and Programs

Personalized Website: myCigna.com

Life can be busy and complicated. So, we created a simple-to-use tools that can help make your life easier (and healthier). That's why there's www.myCigna.com—your online home for assessment and cost tools, plan management, provider directory, ID cards and much more.

Registration is easy:

1. Go to myCigna.com and select "Register."
2. Enter your personal details like name, address and date of birth.
3. Confirm your identity with secure information like your Cigna ID, social security number or complete a security questionnaire. This will make sure only you can access your information.
4. Create a user ID and password.
5. Review and submit.

Cigna One Guide

The **Cigna One Guide**® service can help you make smarter, more informed choices and get the most from your plan. It's our highest level of support that combines the ease of a powerful app with the personal touch of live customer service. Your One Guide personal support, tools and reminders can help you stay healthy and save money. Get in touch with the new Cigna One Guide team by phone, click to chat or via the enhanced **myCigna app**. Once your account is set up, manage your profile to let us know the best way to contact you with important health information, like your Explanation of Benefits or claim updates.

The **Cigna One Guide**® team will help you every step of the way. Our personal support begins with making sure you select in-network providers and facilities and make the most of your current coverage. Call or click to chat with a personal guide any time. Just visit myCigna.com to start - or finish - customizing your very own health journey.

Online and on the go – myCigna.com and myCigna Mobile App. Download your app now from the App Store℠ or Google Play™.

The myCigna Mobile App is all about helping you stay organized and in control of your health – anytime, anywhere – so you can get more out of life.

Download the myCigna Mobile App for your mobile device.*

GET IT ON Google play

Available on kindle fire

Get it at BlackBerry World

Download on the App Store

Wellness Coaching from your Personal Health Team

You have a team of health specialists – including individuals trained as nurses, coaches, nutritionists, clinicians and counselors – who will listen, understand your needs and help you find solutions, even when you are not sure where to begin.

Baltimore County Government is offering **Omada**®, a digital lifestyle change program designed to help you lose weight and build healthy habits that last.

Join today and get:

A professional health coach for tailored support and guidance

A connected scale to monitor progress (and keep for good)

An online community personalized to your interests

Weekly online lessons to educate and empower you

Baltimore County is offering Omada at no cost to employees and their adult dependents who are eligible for Omada and enrolled in a Cigna or Kaiser Permanente plan—a $650 value.

Take Omada's quick health screener to see if you're eligible:

omadahealth.com/baltimorecountymd

Call today to connect with your dedicated coach!
1-877-459-6150

Confidential Health Assessment

At Cigna, your health matters. We're here to make your journey easier. We offer personalized support that meets you where you are, so we can help you get to where you need to be. When you complete the health assessment questions on **myCigna.com**, you answer simple questions about your health and the result is a personalized report of your overall health. It's quick, personal and it's confidential!

24 Hour Health Information Line

What do you do when your child spikes a fever in the middle of the night? Don't worry, wonder or wait — whenever there's a question about health just call **1-800-896-0948** to connect with a specialist trained as a nurse, 24 hours a day.

Discount Program - Healthy Rewards

Save money when you purchase health and wellness products and services for things such nutrition, fitness, vitamins, alternative medicine through the Cigna Healthy Rewards® program. Visit myCigna for online program information or call **1-800-870-3470**.

Cigna OAP/OAPIN/HDHP
Prescription Drug Coverage

With Cigna's pharmacy benefit, you'll be able to receive phone and online support.

The prescription program covers most medications which require a prescription by either State or Federal law and are prescribed by a licensed practitioner.

Prescription Drug List

Cigna's Prescription Drug List (PDL) is an extensive listing of generic and brand name prescription medications. Your pharmacy plan covers the cost of medications on the PDL – all you have to pay is your plan's copays, coinsurance and/ or deductibles. Sometime after Open Enrollment, you'll be able to access that list on myCigna.com.

Your PDL splits medications into three categories, or tiers:

- 1st Tier, Generic Medications:
  Generics have similar strength and active ingredients as their brand name counterparts. You will usually pay less for generic medications.
- 2nd Tier, Preferred Brand Medications:
  These medications will usually cost more than a generic, but may cost less than a non-preferred brand.
- 3rd Tier, Non-Preferred Brand Medications:
  Non-preferred brands generally have generic alternatives and/or one or more preferred brand options within the same drug class. You will usually pay more for non-preferred medications.

Acute Medications

For prescription drugs needed for shorter-term needs such as antibiotics, the plan allows for a 34-day supply per copay up to a maximum 102-day supply with refills based on your physician's instructions. Prescriptions filled at a retail Pharmacy require one copay per monthly supply.

Maintenance Medications

For prescription drugs needed on an on-going (sometimes daily basis), the plan allows for a 102-day supply of maintenance medication with refills based on your physician's instructions. Prescriptions filled at a retail Pharmacy require one copay per monthly supply. Mail order prescriptions require two copays for up to 102 day supply.

Home Delivery Service is for prescription drugs needed on a daily basis, like high blood pressure or cholesterol medications. These are delivered directly to your home mail box. This also saves you money; for a 3 month supply you will pay a 2 month co-pay.

Express Scripts Pharmacy is Cigna's home delivery pharmacy. As part of the first fill of a prescription through Express Scripts Pharmacy, members will need to provide payment information by phone with a Cigna representative or via the myCigna app or website. For assistance call **1-800-896-0948.**

How myCigna.com helps you make the most of your pharmacy plan

You can:

1. Search our list of over 62,000 retail network pharmacies to find a pharmacy near you. If you are on the go and want to access our list on your smartphone, it is GPS accessible which means that we can help you find a pharmacy nearest to you.
2. See your pharmacy claim history, plan details and account balances and compare real-time drug pr at local retail pharmacies and Express Scripts ho delivery. Pricing is shown specifically for your pharmacy plan. The prescription drug price quote tool is also designed to work easily on your smartphone for use on the go.
3. See a complete list of covered prescription drugs and see the category under which they are covered.

Specialty Pharmacy

Managing a complex medical condition isn't easy. The Accredo team of specialty-trained pharmacists and nurses will provide you with the personalized care and support you need to manage your therapy. Accredo will help you work through side effects, check in with you and your doctor to see how your therapy's going, help you get your medications approved for coverage, and more.

To manage your specialty medication Log in to the myCigna® app or website.

Click on the Prescriptions tab and select Manage Prescriptions. Then click the button next to your medication's name. We'll automatically connect you to your Accredo online account portal.

Payment Assistance

If you're having trouble paying for your medication, Express Scripts Pharmacy offers an Extended Payment Plan, which gives you the option to split your bill into smaller payments.

Use the"Price a Medication" feature on the myCigna App today.

Download on the App Store GET IT ON Google Play

Cigna OAP/OAPIN/HDHP
Prescription Drug Coverage

Step Therapy

Step Therapy is a prior authorized program which means that certain medications need approval before they are covered. In Step Therapy you and your doctor follow a series of steps when choosing your medication. Step Therapy encourages you to try the most cost-effective and appropriate medications available to treat your condition. Typically, these medications are generics or low cost brands. You need to try these first before more expensive medications are approved.

When you fill a prescription for a Step Therapy medication, we'll send you and your doctor a letter explaining what steps you need to take before you refill your medication. This may include trying a generic or lower cost alternative, or asking Cigna for authorization for coverage of your medication. At any time, if your doctor feels a different medication isn't right for you due to medical reasons, he/she can request authorization for continued coverage of a Step Therapy medication.

How myCigna.com helps you make the most of Prior Authorization

Some prescription medications require a Prior Authorization review in certain situations before being covered. Prior Authorization verifies that a medication is appropriate for the diagnosis, dosage, frequency and duration of therapy. To initiate a request, have your doctor contact Cigna Pharmacy at 1-877-530-4437.

Supplemental Discount Program

Your plan includes the Supplemental Discount Program, which offers discounts on select prescrip medications that your plan excludes from coverage. You don't need to sign up and there's no cost to participate. All you need to do is use your Cigna ID when filling your prescription. The pharmacist will review a discounted cash price with you. If it works for you, you'll just pay the pharmacy directly.

Kaiser Permanente Select HMO

Kaiser Permanente is a Health Maintenance Organization (HMO) that provides members with a full range of medical care benefits including preventive care services. Members of Kaiser Permanente must select a Primary Care Physician (PCP) from the over 1,400 physicians who practices exclusively in the Kaiser Permanente member centers or from a network of almost 15,000 community physicians who practice in the District of Columbia and Maryland, including Howard and Baltimore counties. It is important that you choose a PCP when you enroll, as this doctor will act as your good-health advocate and coordinate your care.

Kaiser Permanente Physicians

For help in choosing a primary care physician, review the physicians listed in the Kaiser Permanente Provider Directory included with your enrollment information. Physicians are listed according to their specialty and the county in which they practice. You will find two lists of physicians – those who practice in the Kaiser Permanente medical centers and are part of the Mid-Atlantic Permanente Medical Group, and those who practice in the community and are part of our network.

The list of Kaiser Permanente physicians also includes where the physician went to school, where they did their residency, their board certification and if they speak any foreign languages. This information should help you select a physician that best matches the needs of you and your family.

You may select a PCP for yourself and each member of your family. You can opt to have a single physician for your entire family or choose a different physician for each family member. Your PCP will work with you to coordinate your care, referring you for specialty care as needed and act as your good health advocate, guiding you through the preventive care services aimed at keeping you healthy through all your stages of life.

If you do not choose a PCP on your own when you enroll, Kaiser Permanente will choose one for you – selecting a physician from a medical center located close to your home. If you decide that you do not like the PCP selected for you or the one you have chosen for yourself, you may change your physician for any reason at any time. To change your physician, simply contact the Kaiser Permanente member services department at **1-800-777-7902**.

Covered Preventive Care Services

Members will have no copay requirement for preventive care services. Those services include, but are not limited to, the following age and gender appropriate physical exams, screening tests and the corresponding explanation of the results:

- Routine physical examinations
- Well-woman exams — including pap smear and screening mammograms
- Well-child examinations
- Routine age-based immunizations
- Bone mass measurement to determine risk for osteoporosis
- Prostate cancer screening exams and routine screening Prostate Specific Antigen (PSA) tests
- Colorectal cancer screenings
- Cholesterol screening tests

Note: ***Non-preventive issues and services managed during a scheduled preventive visit or service can result in additional charges for those non-preventive services.***

What is not covered as preventive?

The exam, screening tests, or interpretations for the following is not considered preventive:

- Monitoring chronic disease or as follow-up tests once you have been diagnosed with a disease
- Testing for specific diseases for which you have been determined to be at high risk for contracting
- Travel consultations, immunizations, and vaccines

Prescription Benefits

Prescriptions are $12 for generic, $30 for brand name drugs, and $45 for brand-name non-formulary, if filled at a Kaiser Permanente medical center, or $15 for generic, $45 for brand drugs, and $60 for brand-name non-formulary for up to a 30-day supply if filled at a participating community pharmacy. A mail order program is also available, which allows you to receive up to a 90 day supply of maintenance drugs for two copays. When you fill your prescriptions at a Kaiser Permanente Medical Center pharmacy, you will pay the smallest copay amount. Prescriptions can also be filled at participating community pharmacies, such as Giant, Safeway, Rite Aid, Target, Wal-Mart and K-Mart. Prescription copays are higher when filled at participating community pharmacies than when you obtain your drugs at a Kaiser Permanente medical center.

Members are also able to order prescription refills online through the members-only section of the Kaiser Permanente Web site, **www.kp.org.**

Kaiser Permanente Select HMO

Wellness Services

Kaiser Permanente offers a variety of services aimed at preventing illness. Your PCP can encourage you to attend a variety of the "Be Well" classes offered in the Kaiser Permanente medical centers. The list of classes offered is printed in the provider directory and include classes on such topics as asthma management for children, heart failure, pediatric weight management, prenatal care/breastfeeding, smoking cessation, managing high blood pressure and more.

Members can also access a number of online services that Kaiser Permanente offers to aid in weight management, smoking cessation and relaxation. At **www.kp.org/healthylifestyles**, members can learn how to balance weight management and physical fitness through individualized programs. They can create an individualized nutrition plan, a personalized stress management program based on their own sources and symptoms of stress, or a personal plan to help decrease dependency on cigarettes.

Other Plan Features

- When your dependent children age off your Kaiser Permanente plan, they can choose to continue to receive their care through Kaiser Permanente by enrolling on their own through the Kaiser Permanent for Individuals and Family plan. You can find more information on receiving this individual coverage online at **www.kp.org.**
- Kaiser Permanente offers discounted programs for alternative medical services – acupuncture, chiropractic and massage therapy are some examples of those services.
- Managed Mental Health Services are coordinated through the plan (contact **1-866-530-8778** for assistance).
- Kaiser Permanente offers discounts to members on new health club membership when they join through Choose Healthy. Just go to **www.kp.org/choosehealthy.**
- When you get your care and services at a Kaiser medical center, My Health Manager becomes your one stop shop online resource 24 hours a day, 7 days a week. Features include: Email your doctor, view most lab test results, refill most prescriptions, schedule, cancel, or review routine appointments and much more. Go to **www.kp.org/registernow** to get connected.
- Download the Kaiser Permanente mobile app at no cost from your preferred app site. Use the convenient features of My Health Manager right from your smartphone or other mobile device. If you're already registered on kp.org, you're all set to start using your Kaiser Permanente app. If not, you'll need to go **kp.org/registernow** to set up your account from a computer. Then use your new user ID and password to activate the app.

Kaiser Permanente Medical Centers and After Hours Services

- Kaiser Permanente medical centers have multiple specialties under the same roof. Most have primary care services, such as pediatrics, obstetrics/gynecology and internal medicine, and specialty care services in the same location.
- Most Kaiser Permanente medical centers also provide services including laboratory, radiology and pharmacy in a single convenient location.
- For specialty referrals from a Kaiser Permanente physician, the specialist is often available within the same medical center or another area Kaiser Permanente medical center.
- Kaiser Permanente maintains a 24-hour, 7-day/week Medical Advice help line that is staffed by registered nurses who are available to answer urgent as well as routine medical questions over the telephone.
- The South Baltimore County Medical Center in Halethorpe, offers urgent care 24/7, 365 days per year.
- You can see your doctor face-to-face—without visiting the office. You can have a video visit with your personal doctor from home, work, or while on the go. Mental health along with some specialties are also covered through video visits. Whether you want a future appointment or need to be seen right away, just visit kp.org or use our mobile app to schedule. You must be registered at kp.org to take advantage of this service. Not registered? Visit kp.org/register. You may also call Kaiser Permanente to schedule your video visit at 1-800-777-7904 (TTY 711).
- Coming in Q1 2022! Kaiser Permanente Hub-Timonium! Kaiser is opening a 221,795-square-foot center in Timonium housing a broad range of health services and will operate as a one-stop-shop for patients. In addition to primary care, 24-7 urgent care and pharmacy operations, the center will offer medical and surgical specialty care, including optometry, audiology, pain management and other specialties. The Timonium hub will also offer advanced imaging and a lab.

Non-Medicare Plan Options

This chart summarizes the benefits for the Cigna Open Access Plus, Cigna Open Access Plus In-Network, Cigna High Deductible Health Plan (HDHP) and Kaiser Medical plans. These plans are offered to pre-Medicare retirees and eligible dependents not yet eligible for Medicare.

Plan Facts	Cigna Open Access Plus In-Network (OAPIN)	Cigna Open Access Plus (OAP)		Cigna High Deductible Health Plan with Health Savings Account		Kaiser Permanente Select HMO
		In-Network	Out-of-Network	In-Network	Out-of-Network	
Member services	**1-800-896-0948**	**1-800-896-0948**	**1-800-896-0948**	**1-800-896-0948**		**1-800-777-7902**
Group Number	**3333726**	**3333726**	**3333726**	**3333726**		**1651**
COST SHARING LIFETIME LIMITS						
Calendar Year Deductible	$0 Individual / $0 Family	$200 Individual / $400 Family	$300 Individual / $600 Family	$2,500 Individual / $5,000 Family	$5,000 Individual / $10,000 Family	N/A
Calendar Year Medical Out-of-Pocket Maximum	$1,100 Individual / $3,600 Family	$1,000 Individual / $2,000 Family	$1,500 Individual / $3,000 Family	$5,000 Individual / $10,000 Family	$10,000 Individual / $20,000 Family	N/A
Calendar Year Prescription Out-of-Pocket Maximum	$5,500 Individual / $9,600 Family	$5,600 Individual / $11,200 Family	N/A	N/A	N/A	N/A
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
OUTPATIENT PRESCRIPTION DRUG BENEFIT						
Dispensed at Pharmacy*	$12 Generic / $30 Brand Formulary / $45 Brand Non-Formulary (copays apply for each 34 day supply)	$12 Generic / $30 Brand Formulary / $45 Brand Non-Formulary (copays apply for each 34 day supply)		RETAIL **after the annual deductible is met:** Generic: you pay 10% / Brand Formulary you pay 10% / Brand Non-Formulary you pay 10% (for each 34 day supply)		One copay for up to a 30 day supply. $12 Generic / $30 Brand Formulary / $45 Brand Non-Formulary for Kaiser Facility / $15 Generic / $45 Brand Formulary / $60 Brand Non-Formulary at other network pharmacies
Mail Order – Maintenance Medications* Mail order copays do not apply to Specialty Medications.	$24 Generic / $60 Brand Formulary / $90 Brand Non-Formulary (you pay only 2 copays for each 102 day supply)	$24 Generic / $60 Brand Formulary / $90 Brand Non-Formulary (you pay only 2 copays for each 102 day supply)		RETAIL and HOME DELIVERY **after the annual deductible is met:** Generic: you pay 10% / Brand Formulary you pay 10% / Brand Non-Formulary you pay 10% (for each 102 day supply)		$24 Generic / $60 Brand Formulary / $90 Brand Non-Formulary for mail order refills. Up to 90 day supply for maintenance medications
* If you receive a brand name medication when a generic is available, you will pay the cost difference between the generic and name brand plus your copay.						
PROFESSIONAL SERVICES						
Annual Adult Physical	You pay 0% / Plan pays 100%	You pay 0% / Plan pays 100%	You pay 25% / Plan pays 75% after the deductible is met	You pay 0% / Plan pays 100%	You pay 30% / Plan pays 70% after the deductible is met	100% Covered
Gynecology Annual Office Visit	You pay 0% / Plan pays 100%	You pay 0% / Plan pays 100%	You pay 25% / Plan pays 75% after the deductible is met	You pay 0% / Plan pays 100%	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies
Mammography Screening / PAP / PSA Testing (Routine)	You pay 0% / Plan pays 100%	You pay 0% / Plan pays 100% No deductible	You pay 0% / Plan pays 100% No deductible	You pay 0% / Plan pays 100%	You pay 30% / Plan pays 70% after the deductible is met	100% Covered
Well Child Visit	You pay 0% / Plan pays 100%	You pay 0% / Plan pays 100%	You pay 25% / Plan pays 75% after the deductible is met	You pay 0% / Plan pays 100%	You pay 30% / Plan pays 70% after the deductible is met	100% Covered
Primary Care Office Visit	You pay $15 per visit	You pay $15 per visit	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies (waived to age 5)
Specialist Office Visit	You pay $25 per visit	You pay $25 per visit	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies
Physical/Speech/Occupational Therapy Office Visit	You pay $25 per visit 40 days for each therapy per calendar year	You pay $25 per visit Unlimited days per calendar year for all therapies combined	You pay 25% / Plan pays 75% after the deductible is met Unlimited days per calendar year	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay – days/visits limits apply
Acupuncture	PCP $15 / Specialist $25 copay Unlimited days per calendar year	PCP $15 / Specialist $25 copay	You pay 25% / Plan pays 75% after the deductible is met Unlimited days per calendar year	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$15 copay per visit limited to 20 visits per calendar year
Chiropractic Office Visit	You pay $25 per visit Limited to 40 days per calendar year	You pay $25 per visit Unlimited days per calendar year	You pay 25% / Plan pays 75% after the deductible is met Unlimited days per calendar year	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$15 copay applies limited to 20 visits/year
Allergy Shots/Other Covered Injections	You pay 0% / Plan pays 100%	You pay 0% / Plan pays 100% no deductible	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies
Allergy Serum/Testing	You pay 0% / Plan pays 100%	You pay 0% / Plan pays 100% No deductible	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70%	$10 copay applies

Non-Medicare Plan Options cont'd.

This chart summarizes the benefits for the Cigna Open Access Plus, Cigna Open Access Plus In-Network, Cigna High Deductible Health Plan (HDHP) and Kaiser Medical plans. These plans are offered to pre-Medicare retirees and eligible dependents not yet eligible for Medicare.

Plan Facts	Cigna Open Access Plus In Network (OAPIN)	Cigna Open Access Plus (OAP)		Cigna High Deductible Health Plan with Health Savings Account		Kaiser Permanente Select HMO
		In-Network	Out-of-Network	In-Network	Out-of-Network	
Diagnostic Tests	PCP $15 / Specialist $25 copay	PCP $15 / Specialist $25 copay	You pay 25% / Plan pays 75% after the deductible is met Unlimited days per calendar year	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Test covered in full on same day as office visit; $10 copay applies unless on list of $0 copayment preventive screenings
Diagnostic Tests Performed by Lab or Other Testing Facility and Billed Separately from Office Visit	Independent X-ray or Lab Facility Outpatient Facility You pay 0% / Plan pays 100%	Independent X-ray or Lab Facility Outpatient Facility You pay 5% / Plan pays 95% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Approved tests covered in full
INPATIENT CARE HOSPITAL						
Room and Board Preauthorization REQUIRED if Elective	$100 copay per admission, then You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Physician/Surgical Services	You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Anesthesia Services	You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Medical Consultations	You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
ICU/CCU	$100 copay per admission, then You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Maternity/Nursery/Birthing Center	Initial Visit to confirm pregnancy Primary Care Physician – You pay $15 per visit Specialist – You pay $25 per visit Global Maternity Professional Fees You pay 0% / Plan pays 100% Inpatient Facility $100 copay per admission, then You pay 0% / Plan pays 100%	Initial Visit to confirm pregnancy Primary Care Physician – You pay $15 per visit Specialist – You pay $25 per visit Global Maternity Professional Fees You pay 5% / Plan pays 95% after the deductible is met Inpatient Facility / Outpatient Facility You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Skilled Nursing/Rehab Facility Care	You pay 0% / Plan pays 100% 100 days per calendar year	You pay 15% / Plan pays 85% after the deductible is met Combined 120 days per calendar year (in-network and out-of-network)	You pay 25% / Plan pays 75% after the deductible is met Combined 120 days per calendar year (in-network and out-of-network)	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized, 100 days/year
Dialysis/Radiation/Chemotherapy	$100 copay per admission, then You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Hospice	You pay 0% / Plan pays 100%	You pay 5% / Plan pays 95% after the deductible is met	You pay 5% / Plan pays 95% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Physical/Speech/Occupational Therapy	$100 copay per admission, then You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
OUTPATIENT HOSPITAL SERVICES						
Surgical/Anesthesia Services	You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% per visit after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies
Dialysis/Radiation/Chemotherapy – Physicians Office	PCP $15 / Specialist $25 copay	PCP $15 / Specialist $25 copay	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies
Dialysis/Radiation/Chemotherapy – Outpatient Facility	You pay 0% / Plan pays 100%	You pay 5% / Plan pays 95% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies
Physical/Speech/Occupational Therapy	You pay $25 per visit 40 days for each therapy per calendar year	You pay $25 per visit	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies
Outpatient Diagnostic Services	You pay 0% / Plan pays 100%	You pay 5% / Plan pays 95% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies for office visit

Non-Medicare Plan Options cont'd.

This chart summarizes the benefits for the Cigna Open Access Plus, Cigna Open Access Plus In-Network, Cigna High Deductible Health Plan (HDHP) and Kaiser Medical plans. These plans are offered to pre-Medicare retirees and eligible dependents not yet eligible for Medicare.

Plan Facts	Cigna Open Access Plus In-Network (OAPIN)	Cigna Open Access Plus (OAP)		Cigna High Deductible Health Plan with Health Savings Account		Kaiser Permanente Select HMO
		In-Network	Out-of-Network	In-Network	Out-of-Network	
MATERNITY/INFERTILITY SERVICES						
1st Prenatal Visit	Initial Visit to confirm pregnancy Primary Care Physician – You pay $15 per visit Specialist – You pay $25 per visit	Initial Visit to confirm pregnancy Primary Care Physician – You pay $15 per visit Specialist – You pay $25 per visit	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay
Pre- and Postnatal Care and Delivery	Global Maternity Professional Fees You pay 0% / Plan pays 100% Inpatient Facility $100 copay per admission You pay 0% / Plan pays 100%	Global Maternity Professional Fees You pay 5% / Plan pays 95% after deductible is met Inpatient Facility / Outpatient Facility You pay 15% / Plan pays 85% after the deductible is met	Global Maternity Professional Fees You pay 25% / Plan pays 75% after deductible is met Inpatient Facility You pay 25% / Plan pays 75% after the deductible is met	Global Maternity Professional Fees You pay 10% / Plan pays 90% after deductible is met Inpatient Facility You pay 10% / Plan pays 90% after the deductible is met	Global Maternity Professional Fees You pay 30% / Plan pays 70% after deductible is met Inpatient Facility You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Routine Nursery Care	Inpatient Facility $100 copay per admission, then You pay 0% / Plan pays 100%	Inpatient Facility You pay 15% / Plan pays 85% after the deductible is met	Inpatient Facility You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Sterilization/Reverse Sterilization	Physician's Office Primary Care Physician – You pay $15 per visit Specialist – You pay $25 per visit Inpatient Facility $100 copay per admission, then You pay 0% / Plan pays 100% Outpatient Facility You pay 0% / Plan pays 100% Excludes reversal of sterilization	Primary Care Physician – You pay $15 per visit Specialist – You pay $25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met Includes reversal of sterilization	You pay 25% / Plan pays 75% after the deductible is met Includes reversal of sterilization	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies, reversal not covered
Elective Abortions in Inpatient or Outpatient Facility	Inpatient Facility $100 copay per admission, then You pay 0% / Plan pays 100% Outpatient Facility You pay 0% /Plan pays 100%	Inpatient Facility / Outpatient Facility You pay 15% / Plan pays 85% after the deductible is met	Inpatient Facility / Outpatient Facility You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 copay applies in outpatient setting
Artificial Insemination (AI)	Primary Care Physician – You pay $15 per visit Specialist – You pay $25 per visit Inpatient Facility $100 copay per admission, then You pay 0% / Plan pays 100% Outpatient Facility; Professional Services You pay 0% / Plan pays 100% Unlimited dollar maximum	Primary Care Physician – You pay $15 per visit Specialist – You pay $25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met Unlimited dollar maximum	You pay 25% / Plan pays 75% after the deductible is met Unlimited dollar maximum on all infertility	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered at 50% of non-member rate when authorized
InVitro Fertilization (IVF)	Primary Care Physician You pay $15 per visit Specialist – You pay $25 per visit Inpatient Facility $100 copay per admission, then You pay 0% / Plan pays 100% Outpatient Facility; Professional Services You pay 0% / Plan pays 100% Unlimited dollar maximum	Primary Care Physician You pay $15 per visit Specialist – You pay $25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met Unlimited dollar maximum	You pay 25% / Plan pays 75% after the deductible is met Unlimited dollar maximum on all infertility	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	50% copay applies, limited to 3 attempts per live birth up to $100,000 per lifetime

Non-Medicare Plan Options cont'd.

This chart summarizes the benefits for the Cigna Open Access Plus, Cigna Open Access Plus In-Network, Cigna High Deductible Health Plan (HDHP) and Kaiser Medical plans. These plans are offered to pre-Medicare retirees and eligible dependents not yet eligible for Medicare.

Plan Facts	Cigna Open Access Plus In-Network (OAPIN)	Cigna Open Access Plus (OAP)		Cigna High Deductible Health Plan with Health Savings Account		Kaiser Permanente Select HMO
		In-Network	Out-of-Network	In-Network	Out-of-Network	
MEDICAL EMERGENCIES						
Emergency Room	You pay $100 per visit – copay waived if admitted	You pay $100 per visit – copay waived if admitted	You pay $100 per visit – copay waived if admitted	You pay 10% / Plan pays 90% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	Covered in full after $50 copay – copay waived if admitted
ER Follow-up visits	You pay $100 per visit – copay waived if admitted	You pay $100 per visit – copay waived if admitted	You pay $100 per visit – copay waived if admitted	You pay 10% / Plan pays 90% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	Coordinate w/ PCP – Office visit copays apply
Urgent Care Facility	You pay $25 per visit – copay	You pay $25 per visit – copay	You pay $25 per visit – copay	You pay 10% / Plan pays 90% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	Covered in full after $25 copay – copay waived if admitted
MENTAL HEALTH / SUBSTANCE ABUSE						
Inpatient	$100 per admission, then You pay 0% / Plan pays 100%	You pay 15% / Plan pays 85% after the deductible is met	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full
Outpatient	Physician office visit $25 per visit	Physician office visit $25 per visit	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	$10 per visit for individual therapy $10 per visit for group therapy
OTHER SERVICES						
Ambulance	You pay 0% / Plan pays 100% (Includes Air Ambulance when medically necessary)	You pay 5% / Plan pays 95% after the deductible is met (Includes Air Ambulance when medically necessary)	You pay 5% / Plan pays 95% after the deductible is met (Includes Air Ambulance when medically necessary)	You pay 10% / Plan pays 90% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	Covered in full when authorized
Kidney, Cornea Bone Marrow Transplants, Heart, Heart-Lung, Lung, Pancreas, Liver Transplants	Primary Care Physician You pay $15 per visit Specialist – You pay $25 per visit Inpatient Facility $100 copay per admission, then You pay 0% / Plan pays 100% Outpatient Facility – Physician's Services You pay 0% / Plan pays 100%	Primary Care Physician You pay $15 per visit Specialist – You pay $25 per visit Inpatient Facility / Outpatient Facility Physician's Services You pay 15% / Plan pays 85% after the deductible is met (covered at 100% at LifeSource Center)	You pay 25% / Plan pays 75% after the deductible is met	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered in full when authorized
Outpatient Cardiac Rehabilitation	Limited to 40 days per calendar year $15 PCP / $25 Specialist copay	Calendar year maximum: unlimited $15 PCP / $25 Specialist copay	You pay 25% / Plan pays 75% after deductible is met unlimited days per calendar year	You pay 10% / Plan pays 90% after the deductible is met, Limited to 40 days per calendar year	You pay 30% / Plan pays 70% after the deductible is met, Limited to 40 days per calendar year	$10 copay upon Medical Review Necessity (outpatient)
Hearing Aids	You pay 0% / Plan pays 100% of allowed benefit Unlimited dollar maximum, two hearing aids every three years You may use any provider including Amplifon	You pay 0% / Plan pays 100% of allowed benefit Unlimited dollar maximum, two hearing aids every three years You may use any provider including Amplifon	You pay 0% / Plan pays 100% Unlimited dollar maximum, two hearing aids every three years You may use any provider including Amplifon	You pay 10% / Plan pays 90% after the deductible is met, Unlimited dollar maximum, two hearing aids every three years You may use any provider including Amplifon	You pay 30% / Plan pays 70% after the deductible is met, Unlimited dollar maximum, two hearing aids every three years You may use any provider including Amplifon	One hearing aid for each hearing impaired ear every 36 months up to a $1,000 maximum for adults and children
Durable Medical Equipment	You pay 0% / Plan pays 100% Unlimited Maximum per Calendar Year	You pay 5% / Plan pays 95% after deductible Unlimited Maximum per Calendar Year	You pay 5% / Plan pays 95% after deductible Unlimited Maximum per Calendar Year	You pay 10% / Plan pays 90% after the deductible is met, Unlimited Maximum per Calendar Year	You pay 30% / Plan pays 70% after the deductible is met, Unlimited Maximum per Calendar Year	Covered in full when authorized
Diabetic Supplies	Covered under DME or RX – copays may apply	Covered under DME or RX – copays may apply	Covered under DME or RX – copays may apply	You pay 10% / Plan pays 90% after the deductible is met	You pay 30% / Plan pays 70% after the deductible is met	Covered at 80% – 20% copay

Dental Plan – Highlights

Cigna Dental DHMO

Cigna Dental Care is a Dental Health Maintenance Organization (DHMO). You must select and seek services from your DHMO facility. No benefits are available if non-participating dentists are used. For the most current information regarding participating dentists in your area, you may obtain a personalized provider directory by calling Cigna's automated dental office locator at **1-800-367-1037**. You may also visit Cigna's Website at www.cigna.com. You may change your primary dentist selection by calling Member Services. In most cases, the change will take effect on the first day of the following month.

Plan Highlights

- There is no deductible.
- There are no annual dollar maximums.
- There are no claim forms for you to file.
- All preventive care and some restorative care is available with zero copayments from you ($5 office visit copay applies).
- Complex procedures are available for low, pre-set patient charges that are published in the Patient Charge Schedule.

CareFirst BCBS Traditional Dental

The CareFirst BlueCross BlueShield Traditional Dental plan offers a national network of dental providers – 100,000 participating dentist locations nationwide. If you seek care from a CareFirst participating provider, the dentist cannot bill you the difference between their charge and the allowed amount. You are only responsible for deductibles and coinsurance. A non-participating provider will bill for any amount over the CareFirst allowed benefit. Some of the features include:

- No claim forms to file when you receive in-network care
- Each enrolled family member receives up to $1500 in paid benefits per calendar year
- Flexibility to choose any dentist
- CareFirst's Participating Providers file claims for you and cannot balance bill

CareFirst BCBS Preferred Dental PPO

The CareFirst BlueCross BlueShield Preferred Dental PPO plan offers two levels of benefits in one plan. When you need dental care, you may see the dentist of your choice. Benefit levels and out-of-pocket expenses are determined based upon whether you receive dental care from a preferred dentist. Some of the features include:

- Each enrolled family member receives up to $1,000 in paid benefits per calendar year
- Flexibility to choose any dentist
- CareFirst Preferred and Participating Providers file claims for you and cannot balance bill you
- Preventive care is available with no out-of-pocket expense if a CareFirst Preferred Provider is used
- The CareFirst Dental PPO Program offers two levels of benefits in one plan. When you need dental care, you may see the dentist of your choice. Benefit levels and out-of-pocket expenses are determined by whether or not you receive dental care from a preferred dentist.

In-Network Benefits

When you use a Preferred Provider, you receive the highest level of coverage with the least amount of out-of-pocket expense. In order to choose a preferred dentist, please refer to the Preferred Dental Provider directory at www.carefirst.com or contact member services at **1-866-891-2802**.

Out-of-Network Benefits

You may choose to use dentists outside of the network, but your costs may be higher. There are two types of out-of-network dentists:

- Participating dentists are not "preferred" dentists, but they have agreed to bill only up to the CareFirst BlueCross BlueShield allowed benefit amount, thus limiting your out-of-pocket expense.
- Non-participating dentists do not have an agreement with CareFirst BlueCross BlueShield. They may bill you their regular rates, which may increase your out-of-pocket expense. Members who receive care from non-participating dentists must pay for their services at the time the services are rendered and must file a claim for reimbursement directly to CareFirst BlueCross BlueShield.

Baltimore County Dental Benefits Summary

	CareFirst BCBS Traditional Dental	CareFirst BCBS Preferred Dental PPO		Cigna Dental DHMO
Covered Service	Participating or Non-Participating*	In-Network (Preferred)	Out-of-Network	In- Network Only
Deductible per Calendar Year	$100 Per person $200 Per family	$100 Per person $200 Per family	$100 Per person $200 Per family	$0
Maximum Benefit per Calendar Year	$2000 Per person	$1500 Per person		Unlimited
	Plan Pays	**Plan Pays**		**Member Pays**
Preventative Care, Exams, Cleanings, X-Rays, Fluoride	100% when using a participating provider (Non-participating providers can bill the balance)	100%	80%	$5
Restorative Care, Fillings, Crowns, Root Canals	80% after deductible*	80% after deductible	60% after deductible	$5 to $225 See "Patient Charge Schedule" for details
Periodontal Services	50% for limited services after deductible; treatment plan required	80% for limited services after deductible; treatment plan required	60% for limited services after deductible; treatment plan required	$5 to $250 See "Patient Charge Schedule" for details
Implants, Prosthetic Services, Dentures, Bridgework	50% after deductible; treatment plan required	50% after deductible; treatment plan required	30% after deductible; treatment plan required	$20 to $625 See "Patient Charge Schedule" for details
Emergency Care	No additional emergency provisions provided	No additional emergency provisions provided		$45 After regularly scheduled hours
Orthodontia Services	50% ($2000 lifetime maximum) For dependent children only up to age 19	50% after deductible ($1500 lifetime maximum) For dependent children only up to age 19	50% after deductible ($1000 lifetime maximum) For dependent children only up to age 19	See "Patient Charge Schedule" for details

*CareFirst payments based on allowed benefits. Non-participating providers can bill any amount over the CF allowed benefit.

CareFirst BlueCross BlueShield Vision

Davis Vision administers your CareFirst BCBS Vision coverage. Davis Vision, a leading administrator of vision benefits programs throughout the U.S. and abroad, has a provider network consisting of 18,000 private practitioners, independent optometrists and ophthalmologists, opticians and point-of-service retail centers (Wal-Mart, Pearle, Target, Vision Works, etc.).

Large Provider Network

Davis Vision has a comprehensive network of optometrists and ophthalmologists in Maryland and throughout the United States. However, while there are more providers from which to choose, there may be cases where your current eye care provider does not participate in this network. To find a provider near you, please visit **www.carefirst.com**. Click on **Providers & Facilities** tab, then click "Search for Doctor/Facility. Click "Search Now" then click "Continue as Guest". Select the type of provider you are looking for and follow prompts on screen. You can also call Davis Vision at **1-800-783-5602** (Client Code: 9002). Some offices participate for exams only and some provide significant discounts on lenses and frames. You will pay the least amount out-of-pocket by selecting a full-service office and choosing from the Davis tower of frames or Davis contact lens provider.

Benefits in Brief	Davis Provider You Pay	Out-of-Network You Pay
Routine Eye Exam (once every 12 months)	No copay	Plan reimburses up to $45*, you pay balance
Tower Collection Frames (Fashion)	$10	N/A
Tower Collection Frames (Upgrade)	$30	N/A
Non-Tower Frames	Out-of-pocket costs varies**	Plan reimburses up to $35*, you pay balance
Single Vision Lenses Only	Included with frames	Plan reimburses up to $40*, you pay balance
Bifocal/Trifocal Lenses Only	Included with frames	Plan reimburses up to $60/$90*, you pay balance
Contact Lenses (in lieu of eyeglasses)	$10 copay on formulary or $75 Single/$95 Bifocal contact lens allowance towards provider supplied contacts	Plan reimburses up to $75/$95*, you pay balance (Single/Bifocal)

*You are responsible for all charges for services received out-of-network and must file a claim for reimbursement to Davis Vision.

** If your frames cost more than the allowance, you will pay 2 times the difference between the wholesale cost and the $20 allowance. For instance, if the wholesale cost of your frames is $50, your out-of-pocket costs will be determined as follows: $50 - $20 allowance = $30 x 2 $60 (your out-of-pocket cost for the frames)

$50 - $20 = $30 x 2 = $60

If you need glasses and contacts, your plan will only reimburse for one or the other every 24 months. It may benefit you to use your vision plan for the glasses and use **DavisVisionContacts.com** for replacement contacts. To compare your out-of-pocket cost, you may access **DavisVisionContacts.com** or call Davis Vision at **1-855-589-7911.**

Davis Providers

Independent providers with Tower Collection of frames
Independent providers will offer the exclusive Tower Collection. You will pay:
- $10 Fashion frame with a gold tag
- $30 Designer or Premier frame with a red or blue tag
- One $20 wholesale allowance for non-Tower frames

Retailers with selection of frames
National retailers will offer their own selection of frames.
- You will be given a retail allowance of at least $40 (equates to a $20 wholesale allowance) which will be credited towards the retail cost of the frame

All in-network or participating Davis providers will offer the following services at no additional cost.
- One year breakage warranty on plan eyeglasses
- Plastic or glass lenses
- Oversized lenses

CareFirst BlueCross BlueShield Vision

Out-of-Network Providers

Should you choose to visit an eye care professional **not in the Davis network,** you will still receive coverage; however, your **out-of-pocket costs will be higher** than if you had visited a network provider.

Note: ***Please be aware that non-Davis Vision providers will expect the entire payment up-front. You may then seek reimbursement by submitting a claim form to Davis Vision. You will be reimbursed up to your allowed amounts.***

Example Costs
You can save a significant amount of money if you use a Davis Vision provider as shown below.

	You Pay:
Example 1 Single vision with Davis Fashion Frame	$10
Example 2 Single vision with Davis Designer or Premier Frame	$30 ($10 material copay + $20 upgrade)
Example 3 Single vision with a Non-Davis Frame Retail Cost: $200 Wholesale Cost: $50	$60 (2 times the difference between the wholesale cost minus the $20 wholesale allowance) **$50 - $20 = $30 x 2 = $60**

BlueVision Discounted Rates on Special Services

In addition to your standard eye glass coverage, BlueVision also offers discounts or pre-negotiated fees for additional options.

- **Laser Vision correction** – entitled to a discount of up to 25% off providers usual and customary charge or a 5% discount from the Laser center's advertised special at participating Davis providers.
- **Davis Vision Mail Order Replacement Contact Lens Program** – allows significant savings of up to 50% on replacement contact lenses. Davis Vision Contacts will guarantee the lowest price. You would simply call **1-855-589-7911** with a valid prescription for replacement contacts or additional boxes.
- **20% courtesy discount** at most Davis Vision participating offices towards the purchase of items not covered, such as a second pair of glasses.

Tinting	$11
Standard Progressive Lenses	$50
Premium Progressive Lenses	$90 (Varilux™, Kodak™, Rodenstock™)
Scratch Resistant Coating	$20
Ultra-violet Coating	$12
Plastic Photosensitive Lenses	$65 (Transitions™)
Polycarbonate Lenses	$30 (Polycarbonate lenses covered in full for dependent children, monocular patients and patients with prescription ≥ +/- 6.00 diopter.

Does Davis Vision offer same-day service?

There are Davis Vision network providers who have the ability to deliver your glasses within 24 hours, but the lens strength, material design and/or frame style may influence availability of same day services. Please ask your Davis Vision provider when your glasses will be available. For more information call Davis Vision at **1-800-783-5602**. Generally, eyeglasses will be available for dispensing within 5 business days of your order.

You will have the least amount to pay out-of-pocket when you use a full-service Davis office that carries the Davis tower of frames.

Employee Assistance Program – Non-Medicare Retirees

Baltimore County's EAP services are administered by Cigna, and are available to Non-Medicare Retirees and their household members. Cigna EAP is available 24 hours a day, seven days a week, at **1-888-431-4334**. Cigna EAP can also be accessed at: **www.myCigna.com** employer id: **baltimore**

EAP can help you, or a household member in need of assistance, with a wide variety of problems or concerns. EAP provides telephonic consultation, face to face counseling (up to 10 visits with a local EAP provider) per issue, per year, for every household member of a Baltimore County employee or Non-Medicare Retiree. EAP services are not tied to your selection of a County health plan. There is no charge for EAP service. For more information, please contact Cigna EAP at **1-888-431-4334**.

If EAP is not the best setting for your care, you will be assisted with obtaining Managed Mental Health Benefits, available to you, through your County-sponsored health plan.

Child care, elder care and pet care referral services

Whether an Employee or Retiree is seeking assistance with finding an in home daycare, a nanny, or a daycare center, summer camps, an adult daycare setting, or a pet sitter, etc Cigna EAP can assist with finding child care, elder care or pet care services that meet the particular needs of employees. By calling Cigna EAP at **1-888-431-4334**, and asking to speak with a work/life specialist, Baltimore County Employees, Retirees and their household members can receive assistance with finding pre-screened referrals for a variety of work / life needs.

Legal and Identity Theft

Baltimore County Employees, Retirees and their household members can consult with an attorney, for 30 minutes, at no cost. This consultation can occur in person, or via the telephone, and includes consult for a wide range of legal concerns, with the exception of employment law.

In addition, individuals can receive 60 minutes of telephonic support with a fraud resolution specialist, at no cost. Legal and identity theft consultation can be obtained by calling Cigna EAP at **1-888-431-4334**.

Financial Consultation

Financial issues touch the life of every individual. Without the appropriate information or knowledge, these issues can become time-consuming and stressful, affecting job productivity. Cigna EAP's Financial Consultants can assist you with the following financial matters, during a free 30 minute telephonic consultation:

- Managing Personal and Financial Challenges
- Credit Card and Debt Management
- Budgeting
- Tax Questions
- Financing for college
- Investment options
- Mortgage, loans, and refinancing
- Retirement planning
- Estate planning
- And more

Get the help you need:

Call Cigna EAP 24 hours a day, seven days a week, at the toll free number listed below. You will be connected to a Personal Advocate, who will talk with you about your specific situation, and the resources available to you, at no cost, through your EAP program.

Cigna Employee Assistance Program
Call: **1-888-431-4334**
Go online: **www.myCigna.com**
Your Employer ID: baltimore

Labor First
Private Medicare Exchange

Effective January 1, 2021, Labor First will be administering Medical and Prescription benefits for Baltimore County Medicare eligible retirees, dependents and beneficiaries exclusively through the Baltimore County Retiree Private Medicare Exchange. The Baltimore County Insurance Division will continue to administer Dental, Vision and Life Insurance for Medicare Retirees.

Who is Labor First?

Labor First is a Retiree Benefit Administrator and Advocacy Company, not an insurance carrier, that specializes in retiree healthcare. Labor First is available to assist Medicare eligible retirees with not only reviewing and enrolling in available plan options, but they are a committed resource for our members throughout the life of the plan.

Why Labor First?

- **More Options and Better Value:** The plans available to you from Labor First have been designed to provide you with more options and better value without sacrificing quality or coverage. Premiums will be conveniently deducted from your Baltimore County Pension Check.
- **Sustainability over the Long Term:** The transition to the Private Medicare Exchange offers sustainability over the long term through an approach that allows Baltimore County to continue subsidizing your coverage. Baltimore County will continue to subsidize your medical and prescription premiums based on your date of retirement, type of retirement and years of service.
- **Retiree Advocacy and Support:** Labor First advocates go far beyond just enrolling members. Below are few of the services your dedicated advocates can assist with after your enrollment and throughout the plan year:
  - Claims, billing and payment support
  - Real time Physician and pharmacy assistance
  - Medical and Rx Prior Authorizations
  - Medication Look up
  - Card replacements

Have Questions?

Call a Labor First Retiree Advocate dedicated to Baltimore County at 410-431-2226 or Toll Free at 1-855-499-2656 for more information on enrollment and plan offerings.

Life Insurance

Life Insurance offers protection for your loved ones in the event of your death. The County has partnered with MetLife as our Life Insurance vendor. This overview is provided for brief informational purposes only.

Only employees who were enrolled in life insurance benefits and hired prior to 7/1/1997 are allowed to carry Basic and Additional Legacy life insurance into retirement.* Additional, spouse and child life insurance cannot be carried into retirement, regardless of your hire date. Life insurance can only be continued for those retirees immediately eligible to draw a pension from Baltimore County (i.e., if you retire at age 45 but are not eligible to receive a pension check until age 55, you will not be allowed to enroll in life insurance benefits once you are receiving your retirement checks.)

Premiums are set up and automatically deducted from your pension check. Premiums are subject to change annually if the rates for the entire group of County employees requires a change. Please be sure to check your first pension check to verify that life insurance deductions are being taken if you qualified to continue your life insurance benefits.

What Is the Cost of Life Insurance Coverage?

Retirees will receive the same subsidy for Basic Life as they received while they were actively working. The County does not pay any part of the premium for Additional Legacy Life coverage.

Life Insurance Conversion Right

**Employees hired on/after July 1, 1997 are not eligible to continue their life insurance upon retirement except under Individual Conversion rights. You must apply and begin paying for your conversion coverage within 31 days of your coverage end date. Please contact the Insurance Division for more information.*

How Do I Change My Life Insurance Beneficiary?

You may designate or update your life insurance beneficiary information quickly and easily at: **www.baltimorecountymd.gov/mybenefits**. Retirees who do not have access to the internet may contact the Insurance Division to request a "Change of Beneficiary" form.

Your basic life insurance benefit plus your additional benefit (if elected) will be paid to the beneficiary(ies) named. You may select a person(s), your estate, or an organization, such as a charity, as your beneficiary(ies). You must designate a primary beneficiary and have the option of designating contingent beneficiaries. A primary beneficiary is the person(s) who will receive a benefit upon your death. A contingent beneficiary is the person(s) who will receive a benefit in the event that all of the designated primary beneficiaries are deceased at the time of your death. If you name two or more beneficiaries in a class (primary or contingent), two or more surviving beneficiaries will share equally, unless you provide for unequal shares.

It is very important that you update your beneficiary designations as your life situation changes (e.g., marriage, divorce, death, birth of a child, etc.) to ensure that your life insurance proceeds are paid to the appropriate person(s). A change in your life insurance beneficiary election does not change your pension beneficiary designation; they are separate elections and must be updated separately.

Appendix I

BALTIMORE COUNTY GOVERNMENT NOTICE OF PRIVACY POLICY AND PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED IF YOU ARE COVERED BY BALTIMORE COUNTY HEALTH BENEFIT PLANS. PLEASE REVIEW IT CAREFULLY.

This Notice applies to the following Benefit Plans sponsored by Baltimore County, Maryland:

Medical Benefit Plans

- Medical Plans
- Prescription Drug Benefits included with Medical Plans
- Dental and Vision Plans
- EAP and Managed Mental Health Plans
- Health Care Flexible Spending Accounts (FSAs)

These plans are treated as a single plan for purposes of this Notice and the privacy rules that require it. For purposes of this Notice, we will refer to these plans as a single "Plan." Please note that Baltimore County provides personal and demographic information required to establish your eligibility in these plans and provides the funding for the plans. In instances where the use or disclosure of your medical information is required for purposes of treatment, payment or operation of our health plans, Baltimore County has assigned those responsibilities to Plan Administrators.

The Plans covered by this notice may share information with each other when required and as permitted under law. The amount of health information used or disclosed will be limited to the Minimum Necessary to provide or pay for medical care. The Plans may also contact you to provide appointment reminders or other health-related services.

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request, and will be posted on the website maintained by Baltimore County Government that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations**
  - **Treatment:** Generally, and as you would expect, the Plan Administrators are permitted to disclose your PHI for purposes of your medical treatment. Thus, they may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it is important for your treatment team to know your blood type, the Plan Administrators could disclose that PHI in order to allow you to receive effective treatment.
  - **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan Administrators receive a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan Administrators detailed information about the care they provided, so that they can be paid for their services. The Plan Administrators may also share your PHI with other plans, in certain cases. For example, if you are covered by

more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), they may share your PHI with the other plans to coordinate payment of your claims.

- **Health care operations:** The Plan Administrators may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining insurance coverage.

- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

  - **To the Plan Sponsor:** The Plan Administrators may disclose PHI to Baltimore County who is the Plan sponsor and maintains the benefit plans offered to its employees, retirees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the County's Insurance Division for purposes of enrollment and disenrollment, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits.

  - **Required by law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities who monitor compliance with these privacy requirements.

  - **Workers' Compensation:** We may release medical information about you for workers' compensation or for similar programs that provide benefits for work-related injuries or illness.

  - **For public health activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.

  - **For health oversight activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

  - **Relating to decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

  - **For research purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.

  - **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

  - **For specific government functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

  - **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

  - **Uses and Disclosures Requiring You to have an Opportunity to Object:** The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To request restrictions on uses and disclosures:** You have the right to ask that the Plan (or Plan Administrator) limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.

- **To choose how the Plan contacts you:** You have the right to ask that the Plan (or Plan Administrator) send you information at an alternative address or by an alternative means. The Plan (or Plan Administrator) must agree to your request as long as it is reasonably easy for it to accommodate the request.

- **To inspect and copy your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its Administrators if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

- **To request amendment of your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by one of the Plan Administrators, you may request, in writing, that the record be corrected or supplemented. The Plan or Plan Administrator will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its Administrator and/or not part of the Plan's or Administrator's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or Plan Administrator, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- **To find out what disclosures have been made:** For actions that occur on and after April 14, 2003 (the date of this notice) you have a right to request a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and/or its Plan Administrators, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will receive a response to your written request for such a list within 60 days after you make the request in writing. You may make one (1) request in any 12-month period at no cost to you. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices

If you think the Plan or one of its Plan Administrators may have violated your privacy rights, or if you disagree with a decision made by the Plan or a Plan Administrator about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Contact Person for Information, or to Submit a Complaint

If you want more information about Baltimore County's privacy practices with respect to your health plans and who is covered on your plans, contact the County Insurance Division at (410) 887-2568. If you want more information about the privacy practices of the County's Plan Administrators, contact them directly at the Member Services number on your Plan ID card. Additional contact information for the County's Plan Administrators can be found on the County's website.

Privacy Official

Baltimore County's Office of Budget and Finance HIPAA Privacy Compliance Officer:
Health Insurance Administrator|
Rebecca Ellis
400 Washington Ave, Rm 111
Towson, MD 21204
(410) 887-2568

Effective Date
The effective date of this Notice is April 14, 2006.

BALTIMORE COUNTY GOVERNMENT RETIREE HEALTH INSURANCE APPLICATION

1- Applicant's Personal Information

Name		**Street**					
SSN (Last 4)		**City**		**State**		**Zip**	
DOB		**Primary Phone**		**Email**			

If Spouse is Applicant: _____ _____
Retiree Name Retiree SSN (Last 4)

To Be Completed by the Insurance Division	
Ben Eff Date:	DPOL:
Date of Event:	Retirement Date:
Benefit Basis:	Entity:
Years of Creditable Service:	
Completed by:	Date:

IMPORTANT- Please provide address for person(s) being removed: _____

2- Enrollment Type

Type of Event		Add Dependent(s)	Remove Dependent(s)
○ Retirement	○ Open Enrollment	○ Marriage*	○ Legal Separation / Divorce*
○ New Applicant	○ Gain of other coverage	○ Birth/Adoption of a Child*	○ Child over qualifying age
○ Loss of other coverage		○ Other (please explain)	○ Other (please explain)

*** If adding or removing dependent(s), please attach documentation within 31 days of event *Please provide address for person(s) being removed**

3- Benefit Options

Non-Medicare Retirees / Spouses		Dental Plans	Vision Plan
○ Cigna Open Access Plus (OAP – In and Out of Network)	○ Cigna High Deductible Health Plan (HDHP)	○ CareFirst BCBS Traditional Dental	○ CareFirst Davis Vision
○ Cigna Open Access Plus In-Network Only (OAPIN)		○ CareFirst BCBS Preferred PPO	○ Waive Coverage
○ Kaiser Permanente Select HMO		○ Cigna Dental HMO	
○ Waive Coverage		○ Waive Coverage	
Coverage Level : ○ IND ○ Ret+Sp ○ P/C ○ FAM		Coverage Level : ○ IND ○ Ret+Sp ○ P/C ○ FAM	Coverage Level : ○ IND ○ Ret+Sp ○ P/C ○ FAM

4- Dependent(s) Being Added or Removed (Rem)

Name	Add	Rem	Relationship	Gender	Social Security #	Date of Birth	Disabled Y/ N
RETIREE			SELF				
	○	○					
	○	○					
	○	○					
	○	○					

All information I have given on this application is true to the best of my knowledge. I agree to follow the Retiree guidelines and eligibility rules set forth in the Retiree enrollment guide.

Applicant Signature _____ **Date** _____

Return to: Baltimore County Insurance Division
400 Washington Ave Room 111
Towson, MD 21204
bcbenefits@baltimorecountymd.gov
Fax: 410-887-3820 Ph: 410-887-2568

	Plan Name	Customer Service Number	Website
MEDICAL	Cigna Open Access Plus (OAP) Cigna Open Access Plus In-Network (OAPIN) Cigna High Deductible Health Plan (HDHP)	1-800-896-0948	www.myCigna.com
	Kaiser Permanente Select HMO/Prescription	1-800-777-7902	www.kaiserpermanente.org
RX	Cigna Pharmacy Prescription Coverage for Cigna OAP/OAPIN/ HDHP	1-800-896-0948	www.myCigna.com
DENTAL	CareFirst BCBS Traditional Dental CareFirst BCBS Preferred Dental PPO	1-866-891-2802	www.carefirst.com
	Cigna Dental DHMO	1-800-896-0948	www.myCigna.com
HSA	Benefit Strategies, LLC Health Savings Account (HSA)	1-888-401-3539	www.benstrat.com
EAP	Cigna Behavioral Health	1-888-431-4334	www.myCigna.com (Employer ID: baltimore)
VISION	CareFirst BCBS Davis Vision	1-800-783-5602	www.carefirst.com
LIFE INSURANCE	MetLife	410-887-2568	www.baltimorecountymd.gov/ mybenefits
LABOR FIRST	Labor First	410-431-2226 1-855-499-2656	www.laborfirst.com/ baltimorecounty
DEFERRED COMPENSATION	Nationwide Retirement Solutions Karis Cox	443-934-3237	www.baltimorecountydc.com

Baltimore County Office of Budget and Finance
Insurance Division
400 Washington Avenue, Towson, MD 21204

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